of the French Society of Cardiology including all interventional cardiology procedures performed from 2004. We aimed to evaluate "real world" management of patients with coronary artery disease (CAD) according to administrates regions (northern vs. southern) from this registry.

Methods: The present study is focused on data collected between 2004 and 2008. Patient characteristics, treatment options, and procedural techniques were prospectively collected. Patients were recruited in 99 hospitals (55% in private clinics, 45% in public institutions). For this study, France was divided into two parts (Figure).

Results: Over a 5-year period, a total of 298,105 patients underwent coronary angiography (CAG, 59% in northern) and 176,166 patients underwent percutaneous coronary intervention (PCI, 53% in northern). Patients in the southern part were significantly younger (65.3±12.3 vs. 66.9±12.1), had a lower rate of cardiovascular risk factors and less frequently had past medical history of cardiovascular disease than the northern. Indications of CAG were similar in both groups. The proportion of normal CAG (or without significant coronary lesions) was higher in patients of southern France. These patients received more frequently medical therapy and less often underwent PCI when compared to patients from northern France. Distribution of patients according to the type of center was different (71.6% of patients were included in privates centers in southern France compared to 43.3% in northen France). The average number of stents per procedure was more important in southern France (1.56±0.82 vs. 1.51±0.78, p<0.001).

Conclusion: Clinical characteristics and management of patients with CAD differ according to administrate regions. In northern France, patients had a higher cardiovascular risk; however, they received less stent per procedure.

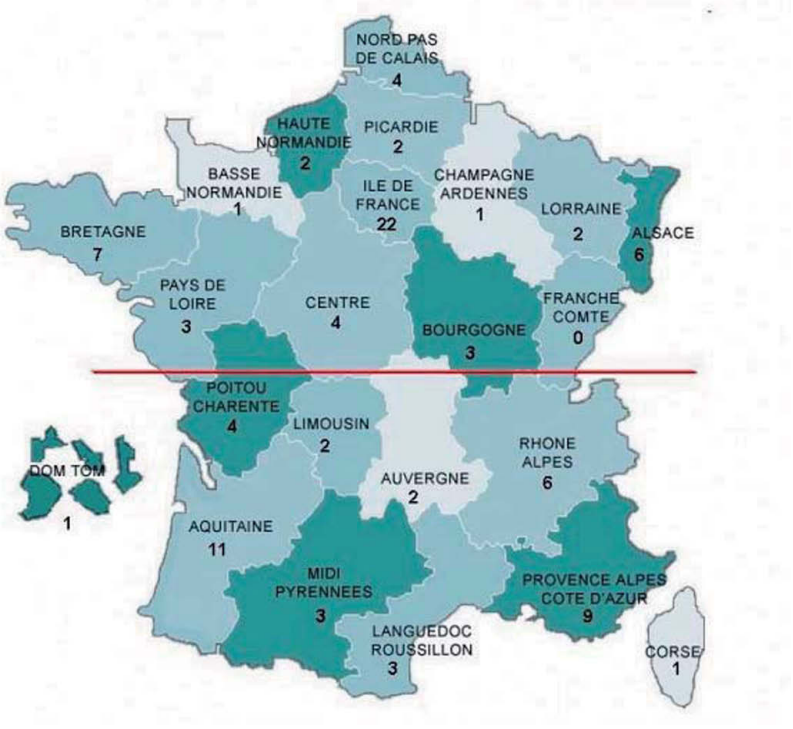

Figure – France divided into two parts northern vs southern

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STEMI in Lorraine nord – Epidemiological, clinical and angiographic features, mortality trends since 1997

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Background: One in two patients starts coronary disease by myocardial infarction (MI). The early management within efficient network and emergency revascularization are key determinants of patient's outcomes. With the evidence-based medicine, our attitudes are influenced by international guidelines. Downstream, it is essential to evaluate our practices.

Methods: Our work is a retrospective single-center comparative study of STEMI patients undergoing catheterization (KT) at Metz hospital cardiology department. We focused on epidemiological, clinical and angiographic features and mortality rate of patients consecutively supported on three 2-year periods since 1997.

Results: Of the 2075 patients hospitalized for MI during 2010-2011 (Period3), 762 underwent KT within 12 hours above 36% (24.5% in 1997-1998 (Period1), 44% in 2005-2006 (Period2)). There is an increase of PPCI with 85% in P3 (76%P1, P267%, >0.001). In the same time, we observe a decrease in rescue angioplasty post thrombolysis (14%P1, 24%P2, 3.7%P3, >0.001). The rate of patient in cardiogenic shock remains stable over the 3 periods (10%). Patients older than 75 years decrease (35.5%P1, 21.2%P2, 18.4%P3). The percentage of patients with multivessel disease increases again between P2 and P3 (31.4%P1, 35.5%P2, 40.4%P3). Direct stenting remains the strategy most frequently used (59.5%P3, 55.8%P2, 1%P1, >0.001). The mortality analysis of the entire population showed no significant difference in the 3 periods (7%). However, there was a decline in mortality in the subgroup of STEMI with cardiogenic shock (62%P1, 48%P2, 23%P3, >0.001).

Conclusion: STEMI patients underwent KT in the first 12 hours in our center appear younger and carrying more severe coronary heart disease. Despite technical changes, in overall mortality has been stable since 1997 except in cardiogenic shock whose outcome continues to improve.

Regular analysis of our patients and practices appears essential for the optimization of our supported.